



*A division of The Board of Healthcare Funders of Southern Africa*

## **POLICIES AND PROCEDURES**

*(Version 4)  
07 September 2011*

## HFMU

### POLICIES AND PROCEDURES

#### **1. ABBREVIATIONS AND DEFINITIONS**

- 1.1 **HFMU:** The HEALTHCARE FORENSIC MANAGEMENT UNIT under the auspices of BHF, consisting of medical schemes and their administrators, as well as their representatives, whose common aim is to curb fraud within the medical scheme industry.
- 1.2 **HFMU member:** The scheme or administrator who joins the HFMU with a view to participate in the fight against fraud. It is usually the scheme's Principal Officer or the administrator's CEO.
- 1.3 **HFMU representative:** The representative of a HFMU member (i.e. an employee of a scheme or administrator, or a third party contracted by a scheme or administrator), who is required by the HFMU member to attend HFMU meetings, handle HFMU enquiries and attend to all other HFMU matters on behalf of the HFMU member. These individuals will normally be those who are involved with the investigation of fraud within their organizations.
- 1.4 **HFMU participant:** The employee of a HFMU member, or the employee of a third party contracted by a HFMU member, who through the terms of his/her employment or contract, come into contact with HFMU-related information or has limited HFMU-related duties or access to the MSFD. These individuals will normally be those who are involved with the investigation of fraud within their organizations or who have administrative duties related to fraud investigations.
- 1.5 **MSFD:** The MEDICAL SCHEME FRAUD DATABASE that is administered by Transunion and that allows HFMU representatives and HFMU participants to load data on the database and to enquire on data loaded by other HFMU representatives/participants.
- 1.6 **HFMU Operational Committee:** This is "the HFMU" i.e. the committee consisting of all the HFMU representatives of HFMU members.
- 1.7 **HFMU Chairman:** The Chairman of "the HFMU" / HFMU Operational Committee.
- 1.8 **HFMU Strategic Committee:** A committee consisting of HFMU representatives who are nominated by the BHF HFMU Co-ordinator, the HFMU Chairman and other HFMU representatives. The role of the Strategic Committee is as follows:
- To handle MSFD governance matters (see MSFD Code of Conduct)
  - To define and approve all strategic matters concerning the MSFD
  - To provide direction and strategy for the HFMU Operational Committee
  - To review misconduct or breach of the HFMU Code of Conduct / Participation Agreement and breach of the MSFD Code of Conduct
  - To champion and promote information-sharing within the medical scheme industry, with the guiding objective of preventing fraud and improving risk management.

## **2. MISSION**

Under the banner of the Board of Healthcare Funders of Southern Africa as the representative body for medical schemes, the HF MU was launched in August 2003. The objective of the HF MU is to curb the incidences of fraud and other inappropriate behaviour which contribute significantly to the cost spiral within the private healthcare funding industry. It is envisioned that through a collective approach, patterns of behaviour of those individuals acting fraudulently or inappropriately can be altered in conjunction with the relevant statutory, regulatory or professional bodies.

The HF MU does not only focus on the activities of healthcare providers but also those of employees of medical schemes and administrators, medical scheme members and brokers.

The HF MU currently enjoys the participation of approximately 93% of the medical schemes industry as well as the support of regulatory bodies, statutory councils and professional associations. The participation of funders ensures that the techniques and tools for identifying, investigating and dealing with fraud are fair and equitable.

Activities impacting on the funding industry such as fraud, abuse, misuse of funds, over-servicing, duplicate billing, kickbacks and over-billing is costing the medical schemes a great deal of money and the value would vary for each medical scheme as benefit structures and scheme rules would usually come into play when these activities are occurring.

## **3. LEGAL FRAMEWORK**

The uniqueness of the South African private healthcare environment poses several challenges for the HF MU. It is therefore imperative that the HF MU operates within a strict legal framework and that investigative techniques do not infringe the rights of individuals and must be done in a fair and transparent manner.

The HF MU is extremely cognizant of the fact that much of the fraud entails collusion between two parties, e.g. a medical scheme member and a healthcare provider, or a medical scheme employee and a healthcare provider or medical scheme member and staff of a medical scheme/administrator.

Investigative tools:

The HF MU makes use of several tools for identifying, investigating and managing fraud.

These are:

Databases – three databases have been established where HF MU representatives and members list those healthcare providers, medical scheme members and employees that are under investigation, or against whom investigations have been finalized.

PCNS – This system can be used to identify for e.g., duplicate practice numbers and other false information, such as false ID numbers, fraudulent signatures and fraudulent registration certificates.

HPCSA link – BHF is linked to this statutory body and thus is able to verify registration and qualifications.

Sharing of information – Participating members are able to share information and avoid duplication of efforts. However, it is important to note that information that is shared can only be used in terms of the HFMU Code of Conduct/participation agreement and MSFD Code of Conduct which all members, representatives and participants of the HFMU must sign and adhere to. HFMU members must also sign the subscriber agreement, including the confidentiality addendum with TransUnion Credit Bureau in order to ensure compliance with the National Credit Act.

Under no circumstances will any HFMU member, representative and participant share any clinical and confidential information pertaining to specific patients. Should the need arise to share confidential information, the member's prior informed consent must be obtained.

Publicity – Publicizing the work of the HFMU has created an awareness of the types of fraud in the environment and will, in time, influence patterns of behaviour. It is important that the HFMU acknowledge the healthcare providers who are practicing ethically and professionally.

Tip Offs line – This facility, operated by Deloitte & Touche, has been made available for use by the HFMU.

These tools have allowed the HFMU to develop a common language and collective guidelines for acting in the best interests of the industry, and not just in the interests of individual medical schemes or administrators. Forensic investigations in the medical schemes environment cannot be viewed as an opportunity for competitive advantage for individual schemes. The entire private healthcare industry is under threat and it is clear that a concerted effort is needed if the industry is to remain viable.

#### **4. OPERATIONAL FRAMEWORK**

It is acknowledged and accepted by all HFMU members that fraud prevention should form part of the administration function of medical schemes and that funds recouped should not be viewed as profit, but as funds belonging to medical scheme members. It is thus imperative that a relationship of trust exists between administrator, scheme and investigative organization.

By agreeing to be members of the HFMU, schemes, administrators and contracted third parties agree and are obliged to act within the protocols and the framework developed by the HFMU.

The complaints process enables healthcare providers, stakeholders and HFMU members / representatives to report any deviations from the HFMU policy and procedure, or from the HFMU Code of Conduct / Participation Agreement and the MSFD Code of Conduct.

The HFMU Strategic Committee will review reports of misconduct, and will then establish an independent disciplinary panel as and when required, consisting of HFMU representatives not on the HFMU Strategic Committee and without a conflict of interest. The HFMU Strategic Committee's review of the complaint will be presented to and reviewed by the disciplinary panel, and then actioned by the HFMU Chairman and BHF HFMU co-ordinator.

### **Complaints process:**

- A written complaint must be addressed to the HFMU co-ordinator.
- The HFMU co-ordinator will furnish the party complained about with full particulars of the complaint and will request them to provide a written response within 30 days (or sooner, depending on the severity of the allegation).
- The complaint as well as the written response will be presented to the HFMU Strategic Committee for review.
- The HFMU Strategic Committee will review the matter and if necessary, a meeting may be scheduled and witnesses may be called.
- The HFMU Strategic Committee will nominate a disciplinary panel and will make its recommendation to the panel.
- The disciplinary panel should, after careful consideration of the facts of the matter, confirm the recommendation or refer it back to the HFMU Strategic Committee, taking into account any mitigating and aggravating factors.
- No employee of the party about whom the complaint was lodged may form part of the disciplinary panel and if a member of the HFMU Strategic Committee, may not attend the meeting where the matter is reviewed.
- The complainant must be informed of the outcome of the complaints process and the reasons thereof.

A formal accreditation process for investigators is being explored and a decision has been taken to allow external investigators who conduct investigations on behalf of medical schemes to participate in the HFMU. These external investigators are also required to enter into the participation agreements with the HFMU and must adhere to the code of conduct and the HFMU policy and procedure.

In the past, medical schemes would have signed an acknowledgement of debt or a settlement agreement with healthcare providers and some of these agreements would even have contained non-disclosure clauses. This would mean that whilst the medical schemes recover funds from these healthcare providers, they would agree not to report the healthcare provider to other stakeholders in the industry, statutory bodies or the authorities. This principle no longer applies. By participating in the HFMU, medical schemes are obliged to follow a process which involves notifying other medical schemes or reporting the outcome to the relevant body where appropriate, for example the criminal justice system or the relevant statutory council. However where there is a legal obligation to report a matter, the HFMU member or representative must comply. One of the main principles and objectives of the HFMU is rehabilitation. Should there be no evidence of rehabilitation once a settlement agreement has been entered into, the healthcare provider would usually be considered to be a second-time offender and then the medical schemes would be obliged to consider a stricter and a more punitive approach.

## 5. LEGISLATION

The Medical Schemes Act no. 131 of 1998 (as amended) provides some guidance in terms of fraud committed by medical scheme members and healthcare providers. There are sections in the Act that refer to fraud and abuse in medical schemes:

Section 28:- refers to duplicate membership

Prohibition of membership of, and claims against, more than one medical scheme. No person shall:

- (a) be a member of more than one medical scheme;
- (b) be admitted as a dependant of –
  - (i) more than one member of a particular medical scheme; or
  - (ii) members of different medical schemes; or
- (c) claim or accept benefits in respect of himself or herself or any dependant from any medical scheme other than the medical scheme of which he or she is a member.

Section 29.2:- refers to members

A medical scheme shall not cancel or suspend a member's membership or that of any of his or her dependants, except on the grounds of -

- (a) failure to pay, within the time allowed in the medical scheme's rules, the membership fees required in such rules;
- (b) failure to repay any debt due to the medical scheme;
- (c) submission of fraudulent claims;
- (d) committing any fraudulent act; or
- (e) the non-disclosure of material information.

This enables medical schemes to prevent members from rejoining the scheme. However, at this stage, the HFMU cannot prevent other schemes from accepting them as members though it is working towards trying to change regulations to set clear boundaries in terms of membership. The establishment of a database, listing fraudulent members, allows medical schemes to be aware of the risk which they may be obliged to take on.

Section 59.2 - refers to service providers.

This makes reference to the payment of claims. Medical schemes may decide whether to pay the member or the healthcare provider. It is however important that HFMU members only use this measure when appropriate.

Section 59.3 - deals with the recovery of funds. Once fraud has come to the attention of the HFMU or any investigations department, payment to the healthcare provider may be stopped and monies recovered.

Section 66 - deals with offences and penalties

It is harder to prove a common law offence than it is to prove a contravention of the Medical Schemes Act, so it is advisable to use both methods when fraud has been committed.

Other useful acts in day-to-day operation:

- The Constitution of the Republic of South Africa, Act no. 108 of 1996
- The Criminal Procedures Act no. 51 of 1977
- The Prevention and Combating of Corrupt Activities Act no. 12 of 2004
- The Prevention of Organised Crime Act no. 121 of 1998
- The Protected Disclosures Act no. 26 of 2000
- The Promotion of Access to Information Act no. 2 of 2000
- The Health Professions Act no. 56 of 1974 (as amended)

The HFMU has and continues to build relationships with the legal fraternity, especially prosecutors, in order to ensure a more efficient process and to provide them with a better understanding of the medical scheme industry.

## **6. UNDERSTANDING MEDICAL SCHEME FRAUD**

There are many complexities and grey areas as to whether an action actually constitutes a fraudulent act or not.

It must be stressed that fraud occurs at all levels: employees, administrators, medical scheme members, healthcare providers, other providers of service, trustees etc

There is more fraud in the healthcare industry than in any other industry in South Africa. It is the biggest crime in terms of monetary value. It is therefore important to understand the drivers of this fraud.

One of the reasons is that there is no visible policing. Another is that long-term habits have become entrenched – people have always got away with it and so they feel they can continue. Even when perpetrators were caught by one medical scheme, because the information was not shared, they would simply defraud other medical schemes in order to pay back the first and thus no disincentive was provided against acting fraudulently. It was also difficult for smaller medical schemes to detect fraud since their budgets to employ fraud investigators were limited. Through collective action and the sharing of information, these medical schemes now have access to the entire industry's forensic investigators. The high cost of medical scheme premiums also makes people feel they are being ripped off and therefore they believe they are justified in ripping off medical schemes.

There are various categories of inappropriate behaviour which should be borne in mind by all forensic investigation units;

Fraud – willful misrepresentation; intent to deceive; prejudice to another.

Abuse – may lack elements of willfulness and intent, includes aspects such as over servicing.

Intent – misrepresentation, prejudice (both potential and actual prejudice should be seen in the same light)

Unethical behaviour – e.g. perverse incentives, kickbacks etc.

It is of the utmost importance that investigators of fraud maintain a high standard of ethics and adhere to the protocols and processes ascertained by the HFMU.

The HFMU supports peer review as an important tool in forensic investigations, as it is sometimes difficult for investigators to determine fraud, abuse, or unethical behaviour especially amongst certain specialist disciplines. A key objective of the HFMU is to encourage healthcare providers to police themselves through peer review processes and through medical scheme member education. The peer review process would be most applicable to clinical issues as opposed to commercial fraud. Any reference to peer review in this document should be seen as an available option to medical schemes, but will pertain to professional bodies such as SAMA, and the HFMU recognizes and supports this process and will always be open to discussion in this regard.

The HFMU plans to change perceptions around the lack of policing of fraud and to ensure that if fraud is committed there will be negative consequences. Second-time offenders are not viewed in a favourable light as the HFMU has adopted a zero tolerance stance, notwithstanding our rehabilitation policy.

The HFMU has already made a difference. It is estimated that the industry has saved hundreds of millions as a result of the efforts of the HFMU. The majority of those committing fraud are not hardened criminals. They commit fraud because the environment is conducive. If perpetrators of fraud know that there are negative consequences to their actions they will be more inclined to change their behaviour. Some medical scheme members are in difficult financial circumstances and will collude with healthcare providers to submit fraudulent claims.

It is also up to medical schemes to promote an understanding of what a medical scheme is. When companies make a medical scheme part of an employee's package, the employees view it as a benefit which automatically should be used up. They don't understand how it works. Medical scheme members should also be encouraged to scrutinize claims and remittance advices more closely. They are either too trusting or they simply do not understand the statements. This attitude should be changed.

The forensic department of an administration organization must be an integral part of the rest of the business, not separate and disassociated. It should be involved in adding new products, implementing new protocols and processes. The forensic department can provide invaluable information, especially with relation to checks and balances and weak points. The forensic departments usually know more about the whole business than others, since it must know the different processes where fraud could take place and get involved in every stage of the business.

## **7. STRATEGIC FOCUS**

In order to develop mechanisms for dealing with dual membership, the HFMU is currently compiling an industry member database.

The HFMU recognizes the need for specific healthcare fraud legislation in SA and is lobbying government for such legislations, along the lines of the American Federal False Claims Act where criteria are clearly laid down and penalties are clear and severe. The HFMU is also lobbying government for specific healthcare fraud courts and prosecutors.

A registry of expertise is currently being developed, which will list special forensic skills in a particular area within the HFMU. A document listing various case studies is in the process of being compiled in order to assist healthcare investigators.

A short term strategic focus of the HFMU is to develop a generic claims database which would assist in establishing trends and anomalies across the industry.

## **8. INVESTIGATIVE APPROACH AND GUIDELINES**

A standardized policy for investigations is necessary for all medical schemes and private investigators who participate in the HFMU.

The following guidelines have been drawn up, not to deal with the detail pertaining to the various investigations that can be conducted, but to provide a framework in which these investigations should be conducted. **The objective of these guidelines is to ensure a fair and transparent process, while still maintaining a high standard of investigation.**

### **8.1 Grounds for an investigation**

- There needs to be legitimate grounds, justification or reason for conducting the investigation.
- The purpose of the investigation must be clear and should not be vague.
- The reason for the investigation and all the allegations must be documented upfront as part of the investigative process. This is done in order to prevent malicious or cold investigations and will prevent the targeting of innocent parties.
- Before an investigation is started, it is necessary to ensure that the investigation is reasonable. This is to ensure that innocent individuals are not investigated. This must be the first step of the investigation and must be thoroughly documented.
- The grounds for investigation can include a report made to the scheme and/or administrator, a suspicious claiming profile or evidence of possible fraud.

### **8.2 Investigation**

- The investigation should be conducted in as short a period as possible, especially in cases where payment has been suspended. It is impossible to set a specific time limit to this as each case under investigation will vary.
- Even though it is important not to compromise an investigation by divulging information, it is important to inform the subject of an investigation as soon as possible of the investigation, as well as what the investigation is about. It is not acceptable to suspend payment to a practice as a result of an investigation and then let it drag on for months without informing the practice as to what the investigation is about. Should a decision have been made to suspend payment, the individual must be informed in writing of this decision. Medical schemes have the right to approach their members for the purpose of claims verification.

- During the evidence gathering stage of the investigation, care must be taken not to defame the practice under investigation. In this regard, care should be taken when approaching random medical scheme members. When approaching medical scheme members, ensure that it is for the verification of the facts, as stated on the claims. The line of questioning should not be leading or misleading.
- When medical scheme members are approached it should be done in a professional manner and unfounded allegations pertaining to the practice should not be made. Always stick to the facts relevant to the case – do not include hearsay, assumptions or speculations in any statements taken from individuals. Read the statement back to the person to ensure that all facts have been accurately recorded.
- If at all possible, questions of a clinical nature should not be posed to medical scheme members who might not be in a position to answer them. Investigators should never question a healthcare provider's clinical judgement.
- Medical scheme members should not be intimidated in any way and investigators need to ensure that there are no language barriers. Members should also be warned about the consequences of making a false statement implicating a practitioner in order to benefit themselves.
- Probes – This investigative method may be used if other avenues of investigation are not appropriate. The purpose of the probe is simply to confirm allegations. It must be clearly understood that the use of a probe by medical schemes may be controversial and all caution must be taken not to be over-enthusiastic to avoid having charges instituted against the medical scheme/administrator. Should a probe be done as part of the investigation, care should be taken to ensure that it is done according to the Constitution and following the guidelines presented by the Criminal Procedure Act and case law on the subject (see appendix A).
- A minimum of two affidavits and or two pieces of evidence are required to proceed, in order to rule out the possibility of an isolated incident or administrative error.
- All matters under investigation should be captured on the MSFD.
- As far as possible, other medical schemes need to be included in investigations in order to increase evidence and/or make it more cost effective.

### 8.3 **Steps to be taken following an investigation**

- Following the investigation, a decision needs to be taken as to how to proceed with the matter. The case should basically follow one, or a combination of the following routes – Administrative, Professional, Criminal or Civil.
- Administrative is where either a settlement is reached between the parties concerned or where claims are reversed. When a settlement agreement is reached, there should be notification to the HFMU.

- Professional is where the matter gets reported to the relevant statutory body such as the HPCSA.
- Criminal is where a criminal case is opened with the SAPS and the National Prosecuting Authority then decides to prosecute or not.
- Civil is where a civil case is opened, mainly in order to recover losses. However that can also be achieved through the criminal process or the administrative process.
- Should the decided course of action be Administrative, with a view to seek a settlement agreement, a meeting with the healthcare provider will be convened. The healthcare provider should always be afforded the option of having representation of his/her choice present at a meeting. (see Appendix B)
- Unless there is a legal obligation to do so, it may not be appropriate to report certain cases to the SAPS and/or a statutory body, and it might be more appropriate to deal with these cases on an administrative level. This also ties in with the philosophy of rehabilitation.
- The evidence at hand and the severity of the issue that was investigated should be used to decide how best to proceed with the matter. Should the healthcare provider not be willing to co-operate with the formal process, the scheme may elect to take the matter further. It is recommended that there be conclusive evidence that the healthcare provider did not choose to co-operate with the investigation.
- All settlements and cases referred to other bodies should be reported to the HF MU operational meetings as well as capturing the facts and pertinent details on the MSFD.
- Quantifications – Investigators should be cautious when extrapolating in order to establish the quantum of the issues identified. Investigators cannot use a % overcharged on one item to apply the same % to all medicines claimed by the healthcare provider. In trying to find the quantum, the relevant medical scheme should recover that which is reasonably estimated to be due to them. Should the healthcare provider believe that the quantification is incorrect then he/she should provide proof to dispute the amount. There should always be some logic to the method of quantification and must be based on supporting documentation and calculations to substantiate the amount being presented as a quantification. Where there is uncertainty about the correctness of quantification, the claims that the scheme dispute or have proven to be incorrect can be reversed against the provider's account with the scheme, and this negates the need for any settlement agreement.

#### 8.4 Settlements

- Settlement agreements must only be reached as part of the discussions at a meeting (appendix B), so as to ensure that the process is transparent and fair on the one hand, and secondly that the settlement agreement is appropriate and in line with the objectives of the HF MU.
- As a general rule, a settlement should not only consist of paying back a specific medical scheme/s, but should also include other measures to facilitate rehabilitation.

- Where a provider pays back an amount to a medical scheme, this must be reported to the HFMU; in order to ensure that the healthcare provider does not inappropriately increase his/her claims volumes to the other medical schemes in order to repay this amount. If such a provider is not reported to the HFMU, it might be considered a harmful business practice, as the settlement agreement is reached to the disadvantage of other medical schemes.
- Investigators should ensure that the matter is reported to any appropriate body if there is a legal obligation to do so.
- Where there is uncertainty about whether to enter into a settlement agreement, the claims that the scheme dispute or have proven to be incorrect should be reversed against the provider's account with the scheme, and this negates the need for any settlement agreement.

## **Appendix A**

***(Probe–1. Investigation: - a thorough investigation, often into illegal or suspicious activities; 2. Check using a probe: - to examine something with a probe)***

In order to keep a probe legal and fair, and in line with the Constitution, the following guidelines need to be followed.

- Any legal prescriptions or requirements are to be complied with at all times.
- There needs to be a reasonable basis for the investigation.
- The evidence that will be gathered through the probe should not be reasonably obtainable through other means.
- During the probe, no enticing should take place, nor should the individual under investigation be placed under any duress. The objective is purely to test allegations and to try and establish whether fraudulent activities take place under normal circumstance. Should any enticement occur or the healthcare provider is placed under duress to provide services or items not covered by a medical scheme, it can then be classified as entrapment and in doing so, the probe negates the transparency aspect of the HFMU
- The probe should be repeated at least twice in order to confirm a positive outcome.
- All steps should be clearly documented through affidavits by the investigator as well as the individual that conducts the probe.
- The chain of evidence should be documented and protected at all times to prevent it from being tampered with.
- Medicines obtained by a probe from any healthcare practitioner should be identified by a qualified healthcare professional, preferably a Pharmacist wherever possible
- Remuneration for a probe should not be conducive to the probe making false accusations and should not be an incentive for the probe to make allegations of things which did not transpire during the visit to the practice.
- When taking the probe's affidavit, ensure that you explain to the probe how important it is to explain exactly and in layman's terms what actually transpired at the practice.

## Appendix B

The objective of meeting with a healthcare provider is to ensure a fair and transparent process, to expedite the conclusion of a investigation, to facilitate the recovery of monies lost as well as rehabilitation and to determine how best to proceed with a matter.

- The healthcare provider should not be forced to attend the meeting.
- The healthcare provider should be encouraged as far as possible to bring a legal representative, and or a representative from his/her professional association to the meeting.
- As far as possible another member of the HFMU should also attend the meeting, alternatively an employee of the BHF should be invited.
- The meeting should be conducted on a “without prejudice” basis.
- Should an agreement be reached, this needs to be converted to writing and will be formal.
- Should no agreement be reached, the healthcare provider needs to be informed as to what the next steps against him/her will be.
- If a first meeting with a healthcare provider is not successful in resolving all the issues and the healthcare provider is not able to answer all the questions and/or allegations, he/she should be afforded the opportunity to check his/her records and revert with sufficient explanations or clarity within a reasonable and agreed time period.
- The outcome of the meeting needs to be reported at the next HFMU meeting.
- The HFMU intends incorporating a standardised settlement agreement into its policy and procedure document as a guideline. Settlement agreements should not contain any form of “trade off” – i.e. the healthcare provider should not be brought under the impression that he/she is exempt from further investigations in a different time period because he/she has signed a settlement agreement. The same would apply to reporting of the matter – the healthcare provider should not believe that because he/she has signed the agreement that he/she will not be reported to the relevant statutory body or to the Healthcare Forensic Management Unit.
- There are two scenarios in which a meeting can be requested with a healthcare provider and they are:
  - The meeting which forms part of the investigation and is convened sake of clarification;
  - The meeting which is convened when the investigation is complete and for the purpose of trying to find a resolution. Should this meeting not result in a resolution then one would need to consider the alternative such as lodging a complaint with HPCSA or the SAPS and/or to institute a civil claim against the healthcare provider.
- One-on-one meetings with healthcare providers should not be permitted in order to prevent allegations of extortion, bribery and corruption.

- Proper notes of what transpired at such a meeting should be kept for ease of reference and clarity. Should the investigator wish to record the proceedings he/she should always inform the healthcare provider and his/her representative of the intention to do so. This would be applicable for a reverse situation also – should the healthcare provider wish to record proceedings, he is obliged to inform the other participants of the meeting. A written record of proceedings must be kept in the format provided in Appendix D.

**Appendix C:**

**INVITATION TO A MEETING**

**Our reference:** \_\_\_\_\_

**Date** \_\_\_\_\_

Dr IM Naughty  
P O Box 123  
Naughtyville  
0007

Per facsimile: \_\_\_\_\_

Dear Dr Naughty

**Request for a meeting to discuss the investigation of your claims**

ABC Health recently completed an investigation of the claims emanating from your practice related to alleged irregularities.

*(Note: provide some detail such as the nature of the alleged irregularity and also the time period under review. Be careful to list only the issues for which you have evidence and not issues which are vague.)*

We would like to schedule a meeting with you about this to give you a fair opportunity to respond to these allegations as well as the outcome of our investigation. We hope that through open discussions we can also find the best possible way to resolve this.

The meeting will also give us an opportunity to determine whether it is appropriate to report the matter to the relevant regulatory body, and/or the South African Police Service. We therefore encourage you to participate in the process.

**You are entitled to legal and/or professional representation at the meeting.**

We strongly suggest that you contact your professional association to get a representative to attend this meeting with you. You are also entitled to have any other legal representation apart from that of your professional association.

**Please contact us within seven days of receipt of this letter to arrange a meeting.**

Kindly contact the writer on \_\_\_\_\_ (telephone number) within seven days of receiving this letter to arrange a mutually convenient date and time for the proposed meeting. We trust that you use this opportunity to address the concerns.

Please note that should you choose to ignore this request, we would be left with no alternative other than to take whatever action be deem necessary.

Yours sincerely

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ABC Health – Forensic Services

**Appendix D:**

**"Forensic Meeting" - RECORD OF PROCEEDINGS**

**Without prejudice**

**Assessment of problem**

**Date of Meeting** : \_\_\_\_\_

**Venue of Meeting** : \_\_\_\_\_  
\_\_\_\_\_

**1. Parties in attendance (including representatives and capacity):**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. Issue at hand:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. Evidence presented:**

\_\_\_\_\_  
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\_\_\_\_\_  
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**4. Practitioner's response:**

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**5. Proposed resolutions:**

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**6. Decisions taken:**

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**7. Confirmation of the record:**

The undersigned parties confirm the contents of this document as an accurate record of the proceedings and confirm that there has been no undue influence exerted by any of the parties present on the other.

**8.** The undersigned parties acknowledge that these proceedings have been conducted on a "without prejudice basis" and that any concession admission or statement by either party during these proceedings may not be used or referred to in any way in subsequent formal proceedings.

SIGNED AT \_\_\_\_\_ ON THIS \_\_\_\_ DAY OF \_\_\_\_\_ 2008.

\_\_\_\_\_  
MEDICAL SCHEME

\_\_\_\_\_  
PRACTITIONER

\_\_\_\_\_  
WITNESS

\_\_\_\_\_  
WITNESS

**Appendix E:**

**ACKNOWLEDGEMENT OF DEBT**

BY: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Insert name of "DEBTOR")

IN FAVOUR OF: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(Insert name of "CREDITOR")

1. The DEBTOR acknowledges herself/ himself to be truly and lawfully indebted to the CREDITOR, in the sum of R \_\_\_\_\_ (insert amount) hereinafter referred to as "THE CAPITAL" being in respect of -
  - 1.1 Monies erroneously paid by the CREDITOR to the DEBTOR in respect of medical services rendered and/or medications dispensed to the CREDITOR during the period \_\_\_\_\_ (insert dates);
  
4. The DEBTOR shall pay the CAPITAL SUM in monthly instalments of not less than R \_\_\_\_\_ (insert amount) each, the first of which is payable on or before the \_\_\_\_\_ day of \_\_\_\_\_ (insert month) with each subsequent instalment to be paid on or before the first day of each and every succeeding month until the whole of the CAPITAL SUM shall have been repaid. The final instalment is payable on or before \_\_\_\_\_.
  
6. This acknowledgement of debt does not constitute a novation of the claim referred to in 1 above. Without derogating from the foregoing, and without prejudice thereto, and in the event of any one instalment not being paid strictly on due date thereof, then the CREDITOR will have the right to claim payment of the full balance of the CAPITAL SUM outstanding.
  
7. All payments in terms hereof shall be made free of any bank exchange or deductions of whatsoever nature at the offices of the CREDITOR at

\_\_\_\_\_  
\_\_\_\_\_  
(insert address)

or such other place as the CREDITOR may from time to time notify the DEBTOR in writing.

9. The DEBTOR chooses domicilium citandi et executandi for all purposes hereunder as follows:

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(insert address)

10. The DEBTOR is entitled to pay the whole of the outstanding balance of the CAPITAL SUM and interest at any time prior to the due date thereof.
11. If the CREDITOR shall institute proceedings against the DEBTOR for recovery of any moneys outstanding as a result of default in payment, the DEBTOR acknowledges that the will be liable for all legal costs incurred by the CREDITOR on the attorney and own client scale, including collection charges.
12. This acknowledgement constitutes the entire acknowledgement by the DEBTOR in favour of the CREDITOR and no warranties, representations or other terms and conditions of whatsoever nature not expressly recorded herein shall be of any force or effect.
13. No variation, alteration, amendment, modification or cancellation of this acknowledgement of debt or any other terms hereof shall be of any force or effect unless reduced to writing and signed by the DEBTOR and confirmed by the CREDITOR in writing.
14. No indulgence, latitude or extension of time which may be allowed by the CREDITOR to the DEBTOR in respect of any payment or any matter provided for herein shall under any circumstances be deemed to be a waiver of the CREDITOR'S rights at any time and the CREDITOR shall without notice be entitled to require strict and punctual compliance with each and every provision or term hereof.
15. The DEBTOR consents to the jurisdiction of any Magistrate's Court having jurisdiction in respect of his person, in respect of any action or proceedings which may be brought against him by the CREDITOR under or in connection with this acknowledgement of Debt.

THUS DONE AND SIGNED by the DEBTOR at the place on the date stated hereunder:

DEBTOR:

PLACE:

DATE:

WITNESS:

ACCEPTED by the CREDITOR at the place on the date stated hereunder:

CREDITOR:

PLACE:

DATE:

WITNESS:

***(Note: Add as an appendix to the AOD another section which allows for a breakdown of which medical schemes are "party to" this AOD.)***